

CRITERIA FOR PRIOR AUTHORIZATION

Humira® (adalimumab)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Adalimumab (Humira®)

CRITERIA FOR RHEUMATOID ARTHRITIS (RA): (must meet all of the following)

- Patient must have a diagnosis of rheumatoid arthritis
- Must be prescribed by a rheumatologist
- Evaluation for latent tuberculosis (TB) with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR JUVENILE IDIOPATHIC ARTHRITIS (JIA): (must meet all of the following)

- Patient must have a diagnosis of juvenile idiopathic arthritis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 2 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR PSORIATIC ARTHRITIS (PSA): (must meet all of the following)

- Patient must have a diagnosis of psoriatic arthritis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR ANKYLOSING SPONDYLITIS (AS): (must meet all of the following)

- Patient must have a diagnosis of ankylosing spondylitis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

APPROVED Criteria

CRITERIA FOR CROHN'S DISEASE (CD): (must meet all of the following)

- Patient must have a diagnosis of Crohn's disease
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has used a conventional Crohn's disease therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional Crohn's disease therapy (see attached table)

CRITERIA FOR PEDIATRIC CROHN'S DISEASE (CD): (must meet all of the following)

- Patient must have a diagnosis of Crohn's disease
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 6 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has had an inadequate response to corticosteroids or immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate

CRITERIA FOR ULCERATIVE COLITIS (UC): (must meet all of the following)

- Patient must have a diagnosis of ulcerative colitis
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has used a conventional ulcerative colitis therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional ulcerative colitis therapy (see attached table)

CRITERIA FOR PLAQUE PSORIASIS (Ps): (must meet all of the following)

- Patient must have a diagnosis of plaque psoriasis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has taken an oral agent for the treatment of plaque psoriasis (see attached table) **OR** patient is a candidate for systemic therapy or phototherapy

LENGTH OF APPROVAL 6 months

APPROVED Criteria

Biologic Agents	
Generic Name	Brand Name
Abatacept	Orencia®
Adalimumab	Humira®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Ustekinumab	Stelara®

Conventional Crohn's Disease Therapies	
Generic Name	Brand Name
Azathioprine	Azasan®, Imuran®
Budesonide	Entocort®
Cortisone	Cortone®
Dexamethasone	Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak®
Hydrocortisone	Hydrocortone®, Cortef®
Mercaptopurine	Purinethol®
Mesalamine	Apriso®, Lialda®, Cariasa®, Pentasa®, Asacol®, Rowasa®, SF-Rowasa®, Fiv-Asa®
Methotrexate	Trexall®, Rheumatrex®
Methylprednisone	Medrol®, MethylPred®, Meprolone UniPak®
Prednisolone	Prelone®, MilliPred®, OraPred®, VeriPred®, Bubbli-Pred®, PediaPred®
Prednisolone/Peak Flow Meter	AsmaPred Plus®
Prednisone	Orasone®, Meticorten®, SteraPred®, Deltasone®, Prenicen-M®
Sulfasalazine	Azulfidine®, Sulfazine®

Conventional Ulcerative Colitis Therapies	
Generic Name	Brand Name
Balsalazide	Colazal®
Budesonide	Uceris®
Cortisone	Cortone®
Dexamethasone	Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak®
Hydrocortisone	Hydrocortone®, Cortef®
Mesalamine	Apriso®, Lialda®, Canasa®, Pentasa®, Asacol®, Rowasa®, SF-Rowasa®, Fiv-Asa®
Methylprednisolone	Medrol®, Meprolone UniPak®, MethylPred®
Prednisolone	Prelone®, MilliPred®, OraPred®, VeriPred®, PediaPred®, Bubbli-Pred®
Prednisolone/Peak Flow Meter	AsmaPred Plus®
Prednisone	Orasone®, Meticorten®, SteraPred®, Deltasone®, Prednicen-M®
Sulfasalazine	Azulfidine®, Sulfazine®

Oral Plaque Psoriasis Therapy	
Generic Name	Brand Name
Acitretin	Soriatane®
Cyclosporine	Sandimmune®
Methotrexate	Trexall®, Rheumatrex®